February 10, 2003

David Martinez
TWCC Medical Dispute Resolution
4000 IH 35 South, MS 48
Austin, TX 78704

MDR Tracking #: M2-03-0607-01
IRO #: 5251

___ has been certified by the Texas Department of Insurance as an Independent Review Organization. The Texas Worker's Compensation Commission has assigned this case to ___ for independent review in accordance with TWCC Rule 133.308 which allows for medical dispute resolution by an IRO.

___ has performed an independent review of the proposed care to determine if the adverse determination was appropriate. In performing this review, all relevant medical records and documentation utilized to make the adverse determination, along with any documentation and written information submitted, was reviewed.

The independent review was performed by a matched peer with the treating doctor. This case was reviewed by a licensed Medical Doctor with a specialty and board certification in Physical Medicine and Rehabilitation. The ___ health care professional has signed a certification statement stating that no known conflicts of interest exist between the reviewer and any of the treating doctors or providers or any of the doctors or providers who reviewed the case for a determination prior to the referral to ___ for independent review. In addition, the reviewer has certified that the review was performed without bias for or against any party to the dispute.

CLINICAL HISTORY

In September 2001, the patient developed right periscapular pain which she attributed to her work in ___. The pain is intermittent and is precipitated by elevation of her right arm. Her physical exam was normal and diagnostic testing was unremarkable. No definite etiology for the pain was determined. A neuromuscular electrical stimulator was prescribed for trial use in July. The prescribing physician noted that the patient's pain had decreased to a tolerable level on 10/2/02 and requested purchase of the stimulator for indefinite use.

REQUESTED SERVICE

A neuromuscular stimulator is requested for this patient.

DECISION

The reviewer agrees with the prior adverse determination.

BASIS FOR THE DECISION

The physician's prescription for the stimulator lists muscle reeducation and strengthening and pain relief as the indications for its use. There was no evidence that the patient had muscle weakness or neuromuscular impairment requiring muscle reeducation. The use of neuromuscular electrical stimulation for the relief of chronic musculoskeletal pain is controversial at best. The medical literature does not provide strong support for its effectiveness. The documentation provided to support its use in this patient includes the manufacturer's promotional literature which includes a list of diverse conditions treated with its stimulator and an abstract of a study using neuromuscular electrical stimulation for treatment of chronic back pain. The evidence is not convincing that long-term neuromuscular electrical stimulation is clearly efficacious or of lasting benefit in the treatment of a nonspecific scapulothoracic pain syndrome as reported on this patient.

The purchase of the neuromuscular electrical stimulator for indefinite use in this patient does not appear medically necessary and appropriate.

___ has performed an independent review solely to determine the medical necessity of the health services that are the subject of the review. ___ has made no determinations regarding benefits available under the injured employee's policy.

As an officer of ___, I certify that there is no known conflict between the reviewer, ___ and/or any officer/employee of the IRO with any person or entity that is a party to the dispute.

___ is forwarding by mail and, in the case of time sensitive matters by facsimile, a copy of this finding to the treating doctor, payor and/or URA, patient and the TWCC.

Sincerely,

YOUR RIGHT TO REQUEST A HEARING

Either party to this medical dispute may disagree with all or part of the decision and has a right to request a hearing.

In the case of prospective ***spinal surgery*** decision, a request for a hearing must be made in writing and it must be received by the TWCC Chief Clerk of Proceedings within 10 days of your receipt of this decision. (20 Tex. Admin. Code 142.5(c)).

In the case of other ***prospective (preauthorization) medical necessity*** disputes a request for a hearing must be in writing, and it must be received by the TWCC Chief Clerk of Proceedings within **20** (twenty) days of your receipt of this decision (28 Tex. Admin. Code 148.3).

This decision is deemed received by you 5 (five) days after it was mailed (28 Tex. Admin. Code 102.4(h) or 102.5(d). A request for a hearing should be sent to: Chief Clerk of Proceedings, Texas Worker's Compensation Commission, P.O. Box 40669, Austin, TX 78704-0012. A copy of this decision should be attached to the request.

The party appealing this decision shall deliver a copy of its written request for a hearing to all other parties involved in the dispute, per TWCC rule 133.308(t)(2).

I hereby certify, in accordance with TWCC Rule 102.4 (h), that a copy of this Independent Review Organization decision was sent to the carrier, requestor, claimant (and/or the claimant's representative) and the TWCC via facsimile, U.S. Postal Service or both on this 10th day of February, 2003.